APPENDIX A - MODIFIERS

MODIFIERS: Procedure codes may be modified under the circumstances described below. The circumstances are to be identified by the addition of a hyphen and the appropriate two-digit modifier code. Only one modifier should be added to any single five-digit *CPT* code, submitted by an individual health care provider. The modifiers that may be used are as follows:

-21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier -21 to the evaluation and management code number. A report may also be appropriate.

-22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure code. A report may also be appropriate.

-23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier -23 to the procedure code of the basic service.

-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier -24 to the appropriate level of E/M service.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a *CPT* code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting the E/M services on the same date. This circumstance may be reported by adding modifier -25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier -57. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier -26 to the usual procedure code.

-TC Technical Component: When the professional component is reported separately, the technical component must be reported separately. The technical component will be the total value less the value for the professional component. Identify by adding modifier -TC to the usual procedure code.

APPENDIX A - MODIFIERS

-27 Multiple Outpatient Hospital E/M Encounters on the Same Date: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier -27 to each appropriate level outpatient and/or emergency department E/M codes(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see **Evaluation and Management Emergency Department Services, or Preventive Medicine Services codes. Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-32 Mandated Services: Services related to *mandated* consultation and/or related services (e.g., PRO, third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier -32 to the basic procedure.

-47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier -47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier -47 would not be used as a modifier for the anesthesia procedures.

-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier -50 to the appropriate five-digit code. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-51 Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.

-52 Reduced Services: Under certain circumstances, a service or procedure may be partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure code and the addition of modifier -52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-53 Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier -53 to the code for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

-54 Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier -54 to the usual procedure code.

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-55 Postoperative Management Only: When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier -55 to the usual procedure code.

-56 Preoperative Management Only: When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier -56 to the usual procedure code.

-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier -57 to the appropriate level of E/M service.

-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier -58 to the staged or related procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier -78. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-59 Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-**62 Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier -62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported without modifier -62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier -80 or modifier -82 added, as appropriate.

-66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier -66 to the basic procedure code used for reporting services.

APPENDIX A - MODIFIERS

-73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed) but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but canceled can be reported by its usual procedure code and the addition of modifier -73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

-74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc. Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier -74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

-76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier -76 to the repeated procedure/service. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier -77 to the repeated procedure/service. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-78 Return to the Operating Room for a Related Procedure During the Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier -78 to the related procedure. (For repeat procedures on the same day, see modifier -76.) **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier -79. (For repeat procedures on the same day, see modifier -76.) **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-80 Assistant Surgeon: Surgical assistant services may be identified by adding modifier -80 to the usual procedure numbers(s).

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-81 Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier -81 to the usual procedure code.

-82 Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier -82 appended to the usual procedure code number(s).

-NP Non-Physician Assistant: A non-physician such as a physician assistant or registered nurse who assists during surgery is to be identified by adding modifier -NP to the usual procedure number.

-90 Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier -90 to the usual procedure code.

-91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier -91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient. **Note that this modifier has also been approved for Ambulatory Surgery Center (ASC) and Hospital Outpatient Use.**

-99 Multiple Modifiers: Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations, modifier -99 should be added to the basic procedure, and other applicable modifiers shall be listed as part of the description of the service.

APPENDIX B

QUICK REFERENCE TABLE

This appendix is provided as a supplement to this schedule of medical fees and is to provide a rapid determination of the dollar amount associated with the particular Procedure Code. The dollar amount specified herein was calculated by multiplying the respective conversion factor of the fee schedule section by the Unit Value of the Procedure Code that was used for billing purposes.

The **Anesthesia** section was not included in this quick reference table, as the determination of the maximum allowable payment incorporates the variable of time required for the provision of each service. Please refer to Anesthesia section of this fee schedule for the maximum allowable payment.

RADIOLOGY CHARGES: Radiology services provided by hospitals or ambulatory surgical care facilities on an outpatient basis are exempt from the variable discount, and are therefore subject to the Maximum Fees in the Radiology Section.

PATHOLOGY AND LABORATORY CHARGES: Pathology and Laboratory services provided by hospitals or ambulatory surgical care facilities are exempt from the variable discount, and are therefore subject to the Maximum Fees in the Pathology and Laboratory Section.

Section Numbers and Their Sequences:

Surgery	10021 to 69990
Radiology	70010 to 79999
Pathology and Laboratory	80048 to 89356
Medicine	90281 to 99199
Evaluation and Management	99201 to 99499
Home Health Procedures/Services	99500 to 99600
Home Infusion Procedures/Services	99601 to 99602
Dentistry	ADA D0120 to D9999